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ABSTRACT

Researchers have divided nursing home residents into long-stayers and short-stayers. While long-stayers rarely return home, they do not necessarily stay long in one institution. Instead, they may transfer from nursing home to nursing home. Although many studies have examined the impact of relocation on nursing home residents, few studies have analyzed reasons for this nomadism. A study of one nursing home was conducted to analyze reasons for nursing home transfers and to distinguish three types of transfers: (1) voluntary transfers where the resident hopes to improve his quality of life; (2) involuntary transfers where the nursing home seeks to transfer a specific resident; and (3) systemic involuntary transfers due to the nature of the hospital-nursing home discharge nexus. Social work case histories of 419 residents discharged between 1978 and 1984 from one proprietary Rhode Island nursing home were reviewed to discern the prevalence of inter-nursing home transfers and motivations. Of 98 residents who transferred, 54 did so because they expected to improve their quality of life by transferring. Twenty-five transferred because the nursing home did not want the resident. Many of these residents were considered combative, physically abusive to staff and other residents, or severely disoriented. Sixteen residents transferred because they forfeited their places when they were hospitalized. Data were missing on three transfers. A three-page list of references concludes the document. (NB)

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NURSING HOME NOMADS: A STUDY OF TRANSFERS

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Nursing Home Nomads: A Study of Transfers

Social work case histories of 419 residents discharged during the first six years of operation of a proprietary nursing home were reviewed to discern the prevalence of inter-nursing home transfers and motivations. Of 98 residents who transferred, half did so because they expected to improve their quality of life. The remainder transferred either because the nursing home no longer wanted them or because they forfeited their place when they were hospitalized.

Introduction

Researchers have divided nursing home residents into "long-stayers" and "short-stayers"(Kane et al, 1983; Keeler et al, 1981; Liu & Manton, 1984; Van Nostrand, 1981). Short-stayers either die soon after admission or return to the community, while long-stayers rarely go home. Long-stayers, however, do not necessarily stay long in any one institution, but may travel from nursing home to nursing home in their final years.

Although substantial research discusses the impact of relocation on nursing home residents (Aldrich, 1963; Borrup, 1982a; Borrup, 1982b; Borrup, 1983; Gutman & Herbert, 1976; Killian, 1970; Lawton & Yaffe, 1970; Miller & Lieberman, 1964; Liebowitz, 1974; Mirotznick & Ruskin, 1984; Pino et al, 1978), few studies analyze reasons for this nomadism. Relocation studies generally trace the status of residents transferred involuntarily, often because a building has closed. Such transfers, however, are not commonplace. They depend upon major changes within institutions themselves.

The commonplace transfers that mark nursing home nomadism occur routinely from institution to institution. Some residents transfer voluntarily. A resident and/or family may prefer a nursing home's religious orientation or ethnic affiliation. One nursing home may be more convenient for visits. Residents may have friends or relatives in a specific nursing home. A resident may find one institution more suited to his/her nursing needs. When an individual enters a nursing home from a hospital, neither the resident nor the family has had time to investigate the kinds of nursing homes available, nor the option to choose a specific home. Often hospital social workers are hard-pressed to find an available bed for an individual by a specific date - a pressure likely to intensify under DRG guidelines. Only after the individual has lived in a nursing home

can s/he and the family evaluate their own desires and options. Once they do, the resident may very well transfer.

Other residents transfer involuntarily. Some may have so alienated staff that the home will not take the resident back if/when the resident is hospitalized. In fact, a home may use hospitalization as an outlet for residents judged "difficult." Proprietary homes may dislike Medicaid recipients, who represent a financial loss. If a resident with depleted funds must rely on Medicaid, a proprietary home may want to transfer him/her.

Other involuntary transfers reflect the vagaries of the health care system. Even well-liked residents may find themselves transferred if they are hospitalized. Since most states will not pay to "keep a bed" empty for Medicaid residents, a resident may enter a hospital from one nursing home, but be discharged to another. Hospital social workers eager to keep within DRG guidelines may be unable to honor a patient's desire to return to a past nursing home. Without payments, moreover, nursing homes are unlikely to hold a vacant bed. Non-hospitalized residents may also be transferred involuntarily. If a resident in a home licensed only for Intermediate-level care suddenly needs G-tube feeding, that procedure will reclassify the patient's needs to "Skilled Nursing" and force him/her to transfer. Similarly, a resident in a home specializing in treatment of the very ill will need to transfer if s/he improves. In homes licensed for all levels of nursing care, the census of comatose or G-tube or confused residents may grow too high for staff to handle competently. If so, the home may want to transfer some of those residents.

This study seeks to analyze reasons for nursing home transfers, to separate 1) voluntary transfers where the resident hopes to improve his quality of life from 2) involuntary transfers where the nursing home

seeks to rid itself of a specific resident, from 3) "systemic" involuntary transfers due to the nature of the hospital-nursing home discharge nexus.

Method of Analysis

Data from social work histories were gathered on the 419 residents discharged from a proprietary Rhode Island nursing home between June 1978 and July 1984, the first six years of the home's operation. The home is not atypical. While immaculate corridors and clean residents testify to a diligent staff, the home has no afffiliation with a University medical center, no staff specifically trained in gerontology, no model programs that make this nursing home a prototype. Like most nursing homes, it is staffed largely with aides; and, like most nursing homes, its architectural placement of patient rooms and living areas evokes models of 1950's motels, with two floors of long corridors lined with mostly one-window, two-bed rooms. Licensed for Intermediate as well as Skilled Nursing service, the home accepts Medicaid patients. Notwithstanding the "ordinariness" of this nursing home, it does not mistreat residents or serve simply as a tax shelter for affluent investors (Mendelsohn, 1975; Moss & Halamandaris, 1977; Vladeck, 1980). Situated in a former mill city, the home serves a population that for the most part worked in nearby jewelry factories or textile mills. Staff are conscientious and caring. When asked to discuss their nursing home, many staff who had worked elsewhere praised the care at this nursing home. In fact, a small percentage of residents are related to staff.

Using the distinction of "long-stayers" versus "short-stayers," the study discounted from the data those 110 residents who had left the nursing home to return to the community. Most of these residents entered the nursing home with a definite discharge plan in progress; and from the start staff, administrators, and patients themselves expected the nursing

home stay to be temporary. Ninety-seven percent of the 203 residents who died and ninety-two percent of the 98 residents who transferred, on the other hand, were admitted "with no discharge plan in progress" or with an uncertain prognosis.

The two research questions for this sample of residents were: 1) What factors distinguished residents who transferred from those who remained in this nursing home? 2) What reasons underlay individual transfers?

To delineate salient resident characteristics, the individual's transfer status (the resident died in this nursing home or transferred) was considered a dependent dummy variable. Since many residents transfer after hospitalization and die during hospitalization, hospitalization was considered an intermedate stage in their final discharge. Independent variables included age at admission, sex, prior residence (whether another institution or the community), the presence of living relatives (constructed as dummy variables), prognosis at admission, and tenure. Independent variables were entered into a multiple regression equation, with transfer status the dependent variable.

To understand motivations behind transfers, the research focused on a review of social work case histories and interviews with the nursing home social worker. For each resident who transferred, a dominant reason was identified. Although this nursing home is proprietary, it admits residents dependent on Medicaid. When a private-paying residents depletes his assets, moreover, the home will not seek to discharge him for that reason.

Results

Of 302 residents who did not return to the community, 98 transferred to another home. Table 1 highlights patient profiles within these two categories. Of residents who transferred, 44 had come to this nursing

TABLE 1. Patient Characteristics of Residents Who Do Not Return To The Community

	Mean Age	N=302 % Female	Months Tenure Mean/Median	% Admitted From Other Institution
Resident Dies in This Nursing Home N=204	81	64.0%	14.2/6.6	.38
Resident Transfers N=98	75	59.6%	10.7/5.2	.44

home from yet another nursing home. These long-stayers have stayed in at least 3 nursing homes.

In response to the first question, What characteristics differentiate residents who transfer from those who do not, multiple regression analysis yielded few answers (Table 2). Residents who transferred tended to be younger and have shorter nursing home stays than other residents, but the betas were not strong. Prior nursing home residence (whether the resident lived in the community or a diffferent institution) showed no impact. Nor did family ties.

The evidence on motivations, however, hightlighted some trends (Table 3). Transfers divided into three categories: 1. Nursing Home Advantage transfers, where the nursing home discharged a resident judged "difficult". Depressed, psychotic, alcoholic, even troubled residents represent major management problems for nursing homes. 2. Resident ntage transfers, where the resident, or the resident's family, sought to improve his quality of life. Often a resident valued the location, the food, the ambiance, the religious orientation, or the ethnic homogeneity of a nursing home. 3. System Advantage transfers, where neither the nursing home nor the resident specifically sought the transfer, but where it occured nonetheless. For this nursing home, which includes both Skilled and Intermediate care units, System Advantage transfers occured when a hospitalized resident forfeited a place.

Over one-quarter of the residents who transferred did so because the nursing home did not want the resident. Many of these residents were combattive, physically abusive to staff and other residents, severely disoriented. Participation observation studies of nursing homes (Bennett, 1980; Gubrium, 1975; Laird, 1979) have noted the unpopularity of "crazy" residents among their peers. People dislike sitting with, rooming with,

Table 2. Multiple Regression Analysis With Transfer As Dependent Variable

Independent Variables	Beta
Age	-.30 ***
Sex	.18 *
Tenure At This Nursing Home	-.22 *
Not Significant:	
Living Spouse	
Living Sibling	
Living Children	
Admitted From Community	

R^2 = .11

*** $P < .001$

* $P < .05$

Table 3. Reasons For Transfer

1. Nursing Home Advantage		25
2. Resident Advantage		54
Food	1	
Location	17	
Friends	8	
Ethnic, Religious Orientation	6	
General Request of Patient or Family	18	
Different Care	4	
3. System Advantage		16
Missing		3

eating with residents they perceive as crazy. Indeed, proximity to confused residents may depress the non-confused (Witzius, 1981). From staff perspective, severely disoriented and combattive residents retard efficient management of "bed and body routines" (Gubrium, 1975), deny staff the grateful satisfaction that they as caregivers want, and, simply, create more work. Staff, moreover, have had no special training in mental or emotional illness; and when confronted with a patient needing help, staff find no support. In-house psychiatric consults are difficult to arrange. Mental health clinics already over-burdened with community patients are reluctant to expand their case load. Indeed, this nursing home had admitted one patient from a private psychiatric hospital, which promised the nursing home follow- up support. The head of nurses reported no assistance, even when the patient relapsed. Within the nursing home nexus these patients face a bleak future. Since the de-institutionalization movement, nursing homes can no longer easily commit a combattive/unmanageable/disoriented resident to a state institution. Instead, these residents travel from nursing home to hospital to nursing home. Over time some may develop a "reputation" among nursing home social workers that will make their hospital discharge difficult. Sixty percent of these transfers had previously lived in a different nursing home, compared to 43% of System Advantage transfers and 33% of Resident Advantage transfers (Table 4).

Admittedly, some "nursing home advantage" transfers are not necessarily disoriented or combattive. From a staff vantage, some residents are simply disagreeable, often coupled with families staff find intensely disagreeable. Hopefully, if the individual and family feel more comfortable in a different nursing home, staff-patient-family relationships may improve.

Table 4. Comparison of Residents By Reason For Transfer

	System Advantage N=16	Nursing Home Advantage N=25	Resident Advantage M=54
1. Admitted From Community	56.3%	40%	66.7%
2. Hospitalized Prior To Transfer	100%	84%	31.5%
3. Median Tenure In This Nursing Home	10 months	4 months	4 months

Unlike Resident Advantage transfers, however, these people are usually shunted to hospitals as an intermediate step. Eighty-four percent of "unwanted" residents did not go directly to another nursing home, but transferred via a hospital. From the nursing home's vantage, hospitalization is a feasible way of discharging a paitnet: a home can legitimately claim the patient "lost" a place and thereby rid itself of him/her, while a home can not so easily "expel" a resident.

System Advantage transfers, though only 17% of the total number of transfers, merit discussion. Although research offers no definitive conclusions that relocations per se are harmful, cavalier reshuffling of hospitalized nursing home residents reinforces the notion of insitutionalization as a loss of self. A resident may suffer a grim "dehumanization" when the hospital social worker announces that s/he will be going to a "new" home, even if the resident preferred the former home. Admittedly, this nursing home attempted to place all residents who wanted to return - an impossible challenge given the frequent intermittent hospitalizations that are part of a normal nursing home stay. Even with a commitment to take back all "their" residents, however, this home was forced to turn away some people, even relatively long-term residents. For system advantage transfers, the median tenure was 10 months; the maximum, 64 months.

Relocation studies generally measure the impact of relocation on mortality or morbitiy. In an institution that strives to offer residents a "home," the social life of the resident bears consideration. In nursing homes many residents form bonds, both with staff and with fellow residents (Bennett, 1980; Gubrium, 1975; Tulloch, 1975; Retsinas, 1985; Laird, 1979). Although studies (Borrup, 1982a; Wells & Macdonald, 1981) have shown that relocated residents often rebuild ties, many of these

studies focused on wholesale involuntary relocation from one facility, where the facility itself was closing. These studies did not examine the impact of "system advantage" transfers where the resident simply "lost" her place when she went to the hospital. A resident with friends in one nursing home may understandably resent being dispatched to a different home and may not so easily reconstruct the fragile social network of the former home.

Finally, the high number of Resident Advantage transfers shatters the image of "the nursing home" as a monolithic institution. Nursing homes vary - a variety that the incidence of Resident Advantage transfers substantiates. Many families see the initial choice of home versus institution as paramount. The particular institution, however, may be an even more significant choice. Residents can improve their quality of life by finding a nursing home more compatible with their values. Seventeen percent of the residents who transferred did so because of "location." Although their new nursing home may be only a few miles from their former one, the change makes visits easier for friends and relatives. In a state so small as Rhose Island, location seems trivial: in forty-five minutes one can drive across the state. Nevertheless, many of these people had lived for years in one community. For them and their families, the ideal nursing home would let them remain in that community, even if a comparable nursing home were only a ten-minute ride away.

Nursing homes also differ in social ambiance. Just as "the elderly" do not represent a monolithic block, so too nursing homes vary. Many residents have learned about the variety of homes either during their own stays in a nursing home, or while visiting friends and relatives. Eight residents transferred because they preferred another home's social life. For six residents, homes with specific ethnic or religious constituencies

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offered more compatible surroundings and companions. Indeed, the social worker at this nursing home reported that often hospitalized patients requested to transfer to this home because of friends or relatives here.

Eighteen residents and families gave no explicit reasons for seeking a transfer. Obviously personalities may clash: some residents may dislike roommates, fellow residents, and/or staff. Similarly, families distraught at the initial institutionalization of a relative may be overly critical of staff they feel are inattentive or a regimen they feel insufficiently stimulating. Residents and families may need to "shop around" for a nursing home with which they feel most comfortable. From the perspective of nursing home staff and administrators, some continually disenchanted families and/or residents may suffer from the nursing home variation on Munchausen Syndrome.

The tenure both of resident advantage and of nursing home advantage transfers is relatively brief - a median length of stay of four months. People, both staff and residents, quickly assessed relationships

Discussion

Most residents admitted to a nursing home "with no discharge plan in progress" never return to the community. Such residents, however, may leave their initial nursing home. Indeed, depending upon the number of intermittent hospitalizations, residents are increasingly likely to become nursing home "nomads" in their final years. In the first six years of this nursing home's operation, almost one-quarter of residents transferred. Seventeen percent of those residents transferred simply because when they went to the hospital, they forfeited their places. If a bed had been available at the time the hospital discharged them, they would have been welcomed back into this nursing home. Although no large-scale studies

document the impact of "systemic" transfers on residents, clearly arbitrary hospital discharge to unfamiliar homes mocks the notion that the nusting home is supposed to provide more than "bed and body care."

Some residents transferred because the staff and/or administration found them too "difficult." Those residents whom the nursing home expressly discharged included combattive residents, residents who tried to injure themselves, and residents abusive to staff. Of 98 residents who transferred, 25 fell into this category.

The largest number of residents transferred because, simply, they recognized the diversity of nursing homes and wanted to try a different one. The variety of nursing homes makes "systemic" transfers all the more unfortunate: if nursing homes are not basically the same, then random discharge to a different home will truly matter to a resident who had been comfortable there.

Transfers themselves needn't be deleterious. If a transferring resident will improve his quality of life, then that transfer is to be lauded and encouraged. Indeed, the fact that patients and families manage to leave one nursing home to try another suggests that individuals recognize meaningful choices among institutions. Transfers that do not aim at improving a resident's quality of life, however, threaten to reinforce the loss of self that is already endemic to institutionalization. When a nursing home transfers a resident that it cannot cope with, that move will not necessarily benefit the resident - unless the resident enters a facility better able to meet his needs. If the nursing home seizes the advantage of a brief hospitalization to transfer both the resident and the responsibility for his welfare to a hospital social worker, then it is not clear that the resident will be bettering his lot with a transfer. More critically, when residents transfer from one nursing home to another simply because they

lost their places, both the nursing home and the individual suffer. The nursing home has become one component of a larger bed and body system network, where residents move capriciously from nursing home to hospital to nursing home, regardless of ties the resident may have formed with staff and fellow residents, regardless of the family's desires, regardless of the nursing home's own professed desire that the resident return. The creation of a community within a nursing home is hampered by the illness of some residents, the confusion of others, the reality of impending death for still others. The presence of systemic transfers makes the formation of a community more difficult. For the resident, moreover, a systemic transfer is a reminder that the "home" of nursing home represents a cruel oxymoron.

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